University of Alberta

Hope and its Relationship to the Working Alliance and Self-Criticism in Counselling

by

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Abstract

Although, hope and the therapeutic alliance, two factors common to all types of therapy, have been found to have a positive effect on counselling outcome, their relationship to each other has not been extensively studied. In addition, while client self-criticism is reported to have a negative impact on the therapeutic alliance, its relationship to hope is unknown. The purpose of the study was to describe the relationship of client reports of hope to the working alliance and self-criticism. Participants were 67 adults aged 18 and over, seeking individual counselling in a community counselling centre. The results indicate that while hope and the working alliance were not correlated, each increased significantly during counselling. As hope increased, psychological symptoms decreased. A strong negative correlation between hope and self-criticism was found. The results suggest that hope is important to both counselling process and outcome.

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CHAPTER I

Introduction

Although, it is now generally agreed that therapy is effective for the treatment of psychological difficulties, it is still not fully known which specific components of therapy lead to client improvement (Lambert, Garfield & Bergin, 2004). Because psychotherapy research shows that all types of psychotherapy are beneficial, it is likely that certain common elements of psychotherapy contribute to client improvement (Lambert et al., 2004; Luborsky et al., 2003; Sexton & Whiston, 1991). Examples of such components include the therapeutic relationship, therapist empathy, catharsis, and client variables. Three elements of therapy that have been reported to be particularly important to therapy success are hope (Edey & Jevne, 2003; Irving et al., 2004), the alliance (Horvath & Symonds, 1991; Kivlighan & Shaughnessy, 1995; Lambert, 1992; Luborsky, 1994; Martin et al., 2000), and the client's level of self-criticism or perfectionism (Blatt, Quinlan, Pilkonis, & Shea, 1995; Rector, Bagby, Segal, Joffe, & Levitt, 2000; Zuroff et al., 2000).

The purpose of this study is to explore the relationship of hope to the therapeutic alliance and self-criticism in order to better understand the roles of these three variables in counselling. Due to mounting evidence in the literature of the prominence of these three variables in the therapeutic process, it was reasoned that an understanding of the relationship among these variables, might facilitate an understanding of their influence on the therapeutic process. While hope and the therapeutic alliance have been studied separately, their relationship to one another within the counselling context has not been thoroughly investigated. Both hope and the therapeutic alliance appear to contribute to

counselling outcome, yet it is unknown whether hope and the alliance contribute independently to the counselling process and treatment outcome, or whether the presence of one inspires an increase in the other. By identifying the relationship between hope and the therapeutic alliance the present study seeks to further clarify whether hope increases during counselling and whether a relationship between hope and the therapeutic alliance exists. Although, self-criticism has been found to negatively impact treatment success (Blatt et al., 1995; Rector et al., 2000), its relationship to hope is unclear. A better understanding of the relationship of hope to self-criticism and the therapeutic alliance may increase our understanding of the counselling process and of the variables themselves.

Study Variables

Hope is emerging in the literature as an important element of counselling (Snyder, Michael, & Cheavens, 1999; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000; Edey & Jevne, 2003; Irving et al., 2004) even if it is not discussed explicitly (Helm, 2004). It has also been proposed as a dynamic element that is common in all therapies (Snyder et al., 1999). Although, hope may seem to be universally felt and understood, providing a concrete description of hope is not easy, and in fact, several definitions are provided within the literature.

According to Snyder et al. (1991), hope consists of the ability to develop goals, the ability to develop viable paths toward one's goals, and the sense of agency that one is able to achieve the specified goals. Meanwhile, Farran, Herth and Popovich (1995) describe hope as consisting of an experiential component, a spiritual component, a relational component, alongside a rational thought process that leads hope to be based in

reality. Farran et al. (1995) also differentiate hope from wishing and optimism. They state that wishing and optimism are based on more specific goals than hope, are based only on positive goals, do not allow for painful feelings, and the goals are less likely to be attained. In other words, wishing and optimism are not always based in reality and the goals of wishing and optimism are less flexible than goals arising from hope. While goals are a main component in the hope definitions of both Snyder et al. (1991) and Farran et al. (1995), the presence of explicit goals play a lesser role in the definition of hope of Dufault and Martocchio (1985).

Dufault and Martocchio (1985) conceptualize hope as existing within contextual, affective, cognitive, behavioural, affiliative and temporal dimensions, with goals being either explicit or implicit. This view of hope acknowledges its presence in many aspects of our daily lives. Dufault and Martocchio (1985) contend that hope in one dimension may influence one's level of hope in other dimensions. It follows from this view of hope that therapy could influence a client's hope at a number of different levels within any theoretical orientation of psychotherapy.

While definitions of hope vary within the literature, all definitions conceptualise hope in a manner that suggests hope may be an important element of psychotherapy. In support of hope being an element common to all types of therapy, Snyder et al. (2002) contend that various techniques and psychotherapy processes from the beginning stages of therapy onward lead to increased hope. Snyder, Feldman, Taylor, Schroeder and Adams (2000) reason that hope increases when goals are attained and counselling increases hope because it increases the ability to pursue goals. Goals, agency and the development of paths toward the goals are addressed by many types of therapy, which

supports the view that these components of hope are common to most, if not all, forms of therapy. Thus, therapy may be beneficial in part due to processes or techniques that increase a client's hope.

Of the aforementioned therapeutic components common to all types of therapy, the therapeutic alliance has been studied the most extensively. The therapeutic alliance was conceptualised by Bordin (1979) as including three main components: agreement on the tasks of therapy, agreement on the goals of therapy, and the bond between therapist and client. In essence, the alliance entails the collaboration between the therapist and client and the relationship that evolves from this partnership. Several studies have shown a positive alliance to be predictive of therapeutic outcome (Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2000; Blatt, Zuroff, Quinlan, & Pilkonis, 1996) and it has been said to account for thirty percent of therapeutic outcome (Lambert, 1992). Because the alliance is an important determinant of both therapeutic outcome and whether clients remain in treatment, an emphasis on collaborating with clients rather than directing them has evolved in many types of therapy, including those that were traditionally more directive and therapist-led (Lambert et al., 2004).

Though both hope and the therapeutic alliance are described in the literature as effective elements that are common to all types of therapy, little research has been conducted to determine how these factors are related. The importance of goals and relationships are emphasised by the theoretical models of the working alliance and hope, which suggests that these two concepts may be related within counselling. Kraatz (2003) researched whether the therapeutic alliance was related to hope, depression and psychological distress prior to counselling and after six counselling sessions. Although,

Kraatz reported a significant increase in hope after six counselling sessions, this increase was not significantly related to changes in the other variables, including the therapeutic alliance. Kraatz also found that the alliance did not predict treatment outcome, which contradicts the results of other previously mentioned studies on the therapeutic alliance. The present study is similar to that of Kraatz; however, attempts were made to address some of the limitations present in the study of Kraatz, which included measuring the alliance only once during the course of counselling and limiting the data collection to a small number of counselling sessions.

Counselling clients' level of self-criticism has also been found to affect counselling processes. Self-criticism is negative thoughts or statements aimed at oneself. While it need not be detrimental, when self-criticism is severe it impacts relationships (Zuroff et al., 2000) and evaluations by others (Powers & Zuroff, 1988; Zuroff, 1994; Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983). For this reason, it is not surprising that it has been found to negatively affect counselling outcomes (Blatt et al., 1995; Rector et al., 2000; Zuroff et al., 2000). A concept related to self-criticism is perfectionism, which involves setting exceedingly high standards that are either difficult or impossible to attain. Because individuals who are perfectionistic are also often self-critical, an understanding of perfectionism also leads to an understanding of self-criticism. Prominent research by Zuroff et al. (2000) found that perfectionistic clients did not contribute to the alliance and with these clients the working alliance did not increase during counselling. This led to the clients having less positive therapeutic outcomes. Self-criticism, which is related to perfectionism, is likely also related to the working alliance. Although, studies exploring the relationship between hope and self-criticism were not

found, self-criticism has been reported to be related to hopelessness (Riley & McCranie, 1990).

Studying the helpful elements of counselling and different types of interventions is important because those treatments that are found to be beneficial for certain populations may become recommended practice, and thereby influence counsellor training (Shadish et al., 1997). Continued research on the beneficial elements of counselling may lead to improvements in counselling services, which would then lead to improved success rates. Although, research has shown that therapy is generally effective and the typical counselling client does improve, it has been noted by Westen and Morrison (2001) that outcome measures indicate clients are not completely symptom-free at the end of counselling. That is, research participants seeking counselling do not necessarily return to the health status of the non-disordered population and follow-up indicates that many participants seek further treatment, suggesting that initial treatment improvement does not remain. Thus, a better understanding of counselling processes is required in order to improve success rates.

The present research is descriptive in nature, and will address the following questions:

1. Does hope increase during the course of counselling?
2. Does a relationship exist between a counselling client's level of hope and the client's rating of the therapeutic alliance?
3. Does the relationship between hope and the therapeutic alliance change when the influence of a client's pre- or post-therapy level of distress is removed?
4. Is clients' level of hope related to their level of psychological distress?

5. Is the therapeutic alliance related to a client's level of psychological distress?
6. Is there a relationship between self-criticism and hope?
7. Is there a relationship between self-criticism and the working alliance?

Overview of the Study

Chapter Two will address the research literature on hope, the therapeutic alliance, self-criticism and the common factors model of psychotherapy. It will further investigate the theoretical support that underlies the relationship between hope and the therapeutic alliance. A description of the study methodology will be presented in Chapter Three, while in Chapter Four the results of the statistical analysis will be described. The study results are further discussed in Chapter Five, as are the implications of the findings and the limitations of the study.

CHAPTER II

Review of the Literature

While the relationship between hope and the therapeutic alliance has received little attention, certain aspects of research in these areas suggest that hope and the alliance are related within the counselling context. Both hope and the alliance appear to be important to the counselling process, as both have been related to treatment outcome (e.g. Irving et al., 2004; Luborsky, 1994); however, their relationship to one another remains unclear. Because self-criticism and the related concept of perfectionism have been reported to affect counselling outcomes (Blatt et al., 1995; Rector et al., 2000; Zuroff et al., 2000), an exploration of the relationship of self-criticism to other important counselling variables may lead to a greater understanding of its influence on counselling processes. The literature review will describe previous research involving the three study variables, much of which indicates that hope, the working alliance and self-criticism are important elements of counselling. Prior to an exploration of the theoretical generalizations that support the likelihood of a relationship between hope and the alliance, the theories and supporting research behind hope and the therapeutic alliance will be discussed. The literature on self-criticism within counselling and the related concept of perfectionism will also be reviewed to provide the basis for exploring its relationship to hope and the working alliance.

Hope Literature

Although hope has not always been accepted as a curative factor by the medical community, in 1959, when Karl Menninger addressed the American Psychiatric

Association on the topic of hope he proposed that it was an important healing element in the practice of medicine. Menninger described hope as an aspect of the Freudian concept of the life instinct, which is a life sustaining function, and as a process that involves a future-oriented search. To illustrate the importance of hope to health, Menninger asked his audience to recall one or more medical cases in which the doctor thought there was little hope, but the patient recovered. The implication was that hope might play a role in such unexplained recoveries. Menninger's influential address provided a conceptual framework that continues to be a foundation for several theories of hope, including those described by Dufault and Martocchio (1985), Edey and Jevne (2003), Farran et al. (1995) and Snyder et al. (1991). Throughout his address, Menninger described ideas that appeared later in many theories of hope, including hope being a possible explanation for the placebo effect, hope inspiring more hope, and the importance of hope existing not just within a patient, but also within the patient's doctors, family members and other care-givers.

Theories of hope.

Since Menninger's 1959 address, the importance of hope to well-being has been expanded and at present several theories of hope exist that can contribute to an understanding of the counselling process. Although, a multitude of definitions and models of hope exist, not all of the descriptions of hope are compatible with one another (Eliott & Olver, 2002). Nevertheless, the way in which hope is conceptualised affects clinical practice (Herth, 2005); for this reason, achieving a comprehensive understanding of hope would be valuable. Underlying many conceptualizations of hope are the common notions that because hope contributes to one's well-being its measurement is warranted,

that hope exists within individuals in varying amounts, and that this amount can be changed (Eliott & Olver). Among the many models of hope are those of Dufault and Martocchio (1985), Farran et al. (1995) and Snyder et al. (1991).

Snyder et al. (1991) conceptualise hope as consisting of three components: a goal, pathways to the goal, and a sense of agency that one is able to attain the goal. According to Snyder, if any of these components are missing, one will not be hopeful. For example, in addition to choosing a goal, one must also be able to envision ways to attain the goal and believe that one is in fact capable of attaining the goal, in order to be hopeful.

According to Snyder et al. (2000) hope is important in primary prevention; that is, hope can protect against psychological problems as it will lead to the attainment of goals, which in turn leads to higher self-esteem and confidence. These authors also contend that people with higher hope are more likely to prevent physical health problems by obtaining health knowledge and acting to promote health, based on their knowledge. Snyder et al. (2000) also explain that once a problem or stressor has arisen, a person with high hope can improve their situation more readily than a person with low hope, as their ability to develop paths toward a goal is greater. Snyder et al. (2000) assert that all systems of psychotherapy are helpful because the client learns more efficient goal attainment. It follows that not only does psychotherapy improve the client's ability to deal with their present situation, but it also improves this ability in the future. Thus, the increased hope from psychotherapy prevents future difficulties as well as assisting in present difficulties.

In addition to discussing the role of hope in preventing physical and psychological problems, Snyder et al. (2000) also discuss the role hope plays in enhancement, which they define as actions designed to attain desired physical and psychological outcomes.

They state that individuals with higher hope will undertake actions to maintain and improve their physical and psychological health. Thus, according to Snyder et al. (2000), the ability to learn and engage in goal-directed thinking, which in their terms is hopeful thinking, is essential to enhancing one's life, solving problems and preventing problems at both a physical and psychological level.

Of the many hope theories in existence, the most broadly defined theory was put forth by Dufault and Martocchio (1985). These authors theorize hope as consisting of two spheres, particularized and generalized, and each sphere as consisting of six dimensions: contextual, affective, cognitive, behavioural, affiliative and temporal. The sphere of generalized hope denotes hope that is future-oriented but toward an unknown, while the sphere of particularized hope includes specific hope objects or goals. These authors theorize that both spheres are necessary for one to remain hopeful because when one's particular hopes become unrealistic or unattainable, the presence of generalised hope allows one to maintain one's overall hope as all hope has not been lost.

The affective dimension of hope (Dufault & Martocchio, 1985) includes both feelings of confidence and of uncertainty toward a hope object in the case of particularized hope, and toward the future in the case of generalized hope. Dufault and Martocchio state the affective dimension is pervasive throughout the entire hoping process. Supportive of this dimension, is the proposition of Jevne (1993) that hopeful people tend to be more confident and have an elevated mood. The cognitive dimension of hope, according to Dufault and Martocchio includes all cognitive activities the hopeful person undertakes during the hoping process. For example, the process of hoping may include remembering something from the past, or perceiving a present situation in a

particular manner in order to maintain or support one's hope. The cognitive component maintains hope within a realistic viewpoint. A third dimension of hope in the theory of Dufault and Martocchio is the behavioural dimension. The behavioural dimension includes physical actions that are motivated by hope as well as those actions one takes to obtain a hope object. Dufault and Martocchio also describe an affiliative dimension of hope, which includes those aspects of hope that involve others. For example, a hope may include a relationship, one may obtain hope from another person, or require a response from another person in order to maintain a hope. A fifth dimension in which hope exists, according to Dufault and Martocchio is a temporal dimension; that is, hope exists across time, in the past, the present, and the future. Dufault and Martocchio contend that some hopes are not time-specific, and thus are protective, as they will not cease to exist. The final dimension of hope identified by Dufault and Martocchio is the contextual dimension. This dimension includes contexts that can enhance or diminish one's present hope, those that allow for the pursuit of hope objects, contexts that elicit the hoping process and situations that challenge one's hope. A context can be a physical environment or a situation. The contextual dimension is dependent on the cognitive dimension, as one's perception, thoughts and understanding of the context will affect whether the context is associated with hope or hopelessness. It is important to note that the six dimensions of hope presented by Dufault and Martocchio are not entirely discrete and hope in one dimension may influence another.

Farran et al. (1995) have also presented a comprehensive conceptualization of hope. Farran et al. describe hope as possessing four main attributes. The first aspect of hope is that one comes to know hope experientially, particularly when one encounters

challenges. Ironically, one can learn about hope through the experience of hopelessness. The second component is described as spiritual or transcendental and its basis is that individuals often connect their hope to their faith or religion. The third attribute identified by Farran et al. is hope as a rational thought process that keeps hope grounded in reality. Within this attribute are goals, resources, an active process, a feeling of control over one's future, and a sense of time, including one's past, present, and future experiences. This attribute includes components similar to those identified by Snyder et al. (1991) and Dufault and Martocchio (1985). The final attribute of hope identified by Farran et al. is that hope occurs within the context of relationships. Thus, hope may develop in a therapeutic relationship. The development of hope, according to Farran et al. occurs within an individual, within relationships, within communities and is influenced by life experiences and spiritual beliefs. These authors describe hope and its attributes as being particularly visible when one is being challenged; moreover, they describe hope that has been challenged as deeper than hope that has never been tested. Farran et al. further describe hope as a precondition for using coping strategies as well as a way of coping through cognitive reappraisal. Successful coping may lead to increased hope; therefore, according to Farran et al., hope and coping are intertwined.

There are a number of differences in the theories of Snyder et al. (1991), Farran et al. (1995) and Dufault and Martocchio (1985). While the model of hope supported by Snyder et al. is very specific and goal oriented, the concept of Dufault and Martocchio is more comprehensive and consists of more facets of hope, including those components of hope that are more general and non-specific. The main components of hope specified by Snyder et al. resemble the cognitive and behavioural dimensions and the particularized

sphere of the Dufault and Martocchio model of hope. An additional difference is that while Snyder's hope theory was first conceptualized and then tested, the theories of Dufault and Martocchio (1985) and Farran et al. (1995) were developed from research findings. Overall, the theories of Dufault and Martocchio (1985) and Farran et al. (1995) contain many similarities, including the identification of relationship and spiritual components of hope and being grounded in research.

Another theory of hope was described by Nunn (2005), who specified an important precondition to hoping. Nunn described hope as being present only when uncertainty is present; thus, hoping has a future orientation. In effect, one does not hope for something if it is known that it will absolutely occur. Nunn explained hope as consisting of three parts: a belief that something is possible but not certain, a desire to achieve the end, and a judgement that the hoped for object is in some sense good and therefore worthy of being hoped for. While Nunn states that hope cannot be changed wilfully, it can change indirectly as a result of information gathering that leads to a change in one's beliefs, desires, or judgements. As in other theories (e.g. Dufault & Martocchio, 1985; Farran et al. 1995), past, present and future experiences are said to influence one's hope. Nunn also described hope as being a situation in which one experiments with different hypothetical life situations, which may lead to a plan.

Like Nunn (2005), Averill and Sundararajan (2005) support the context of uncertainty in hope. However, these authors described the relationship between hope and an uncertain future as curvilinear; that is, if the hoped for result is either near certainty or improbability, the hope may be rejected. Other constraints on hope described by Averill and Sundararajan, referred to as rules by the authors, are moral constraints, in which an

individual may hope for only certain things that he or she believes are morally good, and an action condition, in which the hoping person is expected to act in ways to bring about the hoped for outcome. Finally, these authors state a priority rule that if the hoped for outcome is vital, the other constraints on hope may be set aside in order for the individual to maintain hope.

The use of the word hope in spoken language was examined to further understand hope (Eliott & Olver, 2002). During interviews about do-not-resuscitate orders (DNR's) with cancer patients, Eliott and Olver noted that the meaning of hope was different when patients used the term as a verb or adverb and when they used the term as a noun. As a noun, the existence of hope sometimes appeared dichotomous; that is, it could be either present or entirely absent, which was determined by the doctor. As such, for the patients, hope appeared to dictate what the future held, thereby influencing their current medical choices and actions. At times, hope as a noun was discussed as a subjective presence that could fluctuate, and although at these times it was not perceived as being determined by the doctor, the doctor could influence its fluctuations. This aspect of the patients' hope is important for caregivers to understand, as their actions appear to unintentionally influence the patients' hope or cause it to change. In contrast, when patients used the term "hope" as a verb, it was entirely subjective and derived internally, rather than from the doctor's perception. Hope in this sense protected the patient from an entirely negative view of their medical condition and future. Overall, Eliott and Olver found that their study participants understood hope in a number of different ways and used these different understandings at different times. Hope was ultimately understood by the patients as exerting a positive force over their physical and emotional health.

Eliott and Olver's description of hope incorporates many of the concepts within the model of Dufault and Martocchio's (1985), including that hope exists within relationships, situations, and influences behaviour, and can be directed toward a very specific hope object, or have a more general existence. Because Eliott and Olver found that hope was perceived differently at different times, these authors wondered if one definition of hope is achievable. Without a precise definition of hope that is applicable to all people at all times, measuring hope would be difficult and imprecise because the measures would not capture all possible meanings of hope or be understood by participants similarly.

Less developed conceptualizations of hope have also been described. In his description of the stages of hope in terminally ill patients, Bustamante (2001) described hope as personal. Although, he described stages in terms of themes of hope, which can be seen as general, he reports that each person's hope will be centred around different things based on their own internal and external experiences.

Campling (2002) states that hope is about connecting with others, and within the context of a healthy relationship, connection will lead to a sense of agency. This definition of hope is similar to the affiliative dimension of hope in the theory of Dufault and Martocchio (1985) and the relationship aspect of hope proposed by Farran et al. (1995). Campling describes despair as being linked to disconnection or the absence of connection, which in turn leads to a sense of helplessness. According to Campling, because of the hope brought on by connection, connection can be seen as leading to change. Campling states that patients who do not have a strong alliance with their therapist are at-risk for suicide due to the despair theorized to be brought on by

disconnection. This linking of relationships to hope can be used to theorize the change process in therapy, and to explain the consistent finding that hope and the therapeutic alliance are both important in therapy.

The existence of hope within helping relationships other than counselling has been studied. O'Hara (2001) explored hope within doctor-patient relationships and described hopeful patients as being focussed on the future and being active participants in the search for treatment options. O'Hara also distinguished optimism from hope by describing optimism as being based on past experience and statistical probability, and hope as being based on future possibility, which contrasts with the temporal dimension of hope of Dufault and Martocchio (1985), that hope can exist in the past, present and future. In addition, O'Hara stated that optimism is based on external information, while the origin of hope is internal and can change as circumstances change. There is not yet agreement in the literature on the distinction between hope and optimism. For example, Farran et al. (1995) differentiate optimism from hope by describing the goals of optimism as being more specific, more positive and less attainable than those based on hope. Snyder (1995) states that hope differs from optimism as it includes pathways to a goal, whereas optimism does not. Thus, the distinction between hope and optimism is unclear. Even though O'Hara described hope as internal and optimism as externally derived, she acknowledged that the doctor-patient relationship can influence the patient's hope, as she offers several strategies for physicians to use in order to increase patients' hope.

While the previously cited theories appear to be attempts at generalizations about the main features of hope, Jevne (2005) describes hope as personal and based on one's own experiences. She contends that each person has their own theory on hope, which

includes where hope originates, what factors can increase or decrease one's hope and what its focus should be. Such a view of hope has implications for whether or not it can be effectively measured. Jevne does agree, however that hope is multidimensional, as she also describes hope as an orientation to life. She states that one's approach to the world includes emotions, cognitions, behaviours and contexts, which leads to the many dimensions in which hope exists.

Hope in counselling.

Within the counselling context, Edey and Jevne (2003) contend that hope is important in the healing process for both counsellors and their clients. Hope has also been proposed as a non-specific factor common to all systems of counselling (Snyder, Michael & Cheavens, 1999), while hopelessness has been implicated in both medical and psychiatric disorders (Nunn, 1996).

The process of hope in therapy has been explored by Babits (2001), who describes hope within psychotherapy as increasing when lack of hope has been acknowledged. Babits labels this phenomenon *the Phoenix Juncture*. Babits states that when treatment stagnates, the client and the treatment may appear hopeless. At this time, if the therapist acknowledges his or her own feelings of hopelessness with regard to treatment, two things occur to increase the client's hopefulness. First, the client and the therapist reconnect on the basis of the communication and the client is able to perceive evidence of evoking a response in the therapist. In essence, the client feels less isolated when the feeling of hopelessness is acknowledged because it becomes a shared feeling within the client-therapist relationship. Second, the client is also able to own the feeling as his or her own message being mirrored back by the therapist. According to Babits, the *Phoenix*

Juncture leads to a changed client-therapist relationship in which the client feels they have successfully attained hope from a state of despair. Babits' theory of the *Phoenix Juncture* contains traits of both the affiliative dimension and the affective dimension of hope within the model of Dufault and Martocchio (1985).

Similarly, Helm (2004) describes hope as occurring within the therapeutic relationship in psychoanalysis. The types of hope Helm described within therapy include unrealistic hope that maintains positive affect, hope that is implicit and not consciously communicated, and hope that is addressed directly during the therapeutic dialogue. Thus, hope can exist within many different forms in therapy, and it does not need to be addressed explicitly in order to be helpful in therapy.

Irving et al. (2004) studied the role of hope prior to and during counselling as it related to therapeutic outcome, well-being and level of functioning. These authors found that prior to and throughout treatment, higher hope was associated with increased well-being, increased coping, better functioning and fewer symptoms. In addition, it was found that hope continued to significantly contribute to outcome, when variables such as current coping were statistically controlled. The relationship between hope and coping also continued to be statistically significant when well-being, level of functioning and symptoms were controlled. This indicates that hope contributes to therapeutic outcome beyond level of distress and level of coping. Irving et al. based their conceptualization of hope on the theory put forth by Snyder. Upon exploring how hope changes over the course of therapy, Irving et al. found that clients' sense of agency increased at the beginning of therapy, while their pathways thinking increased during later stages of therapy.

In a study on hope and substance abuse treatment, it was found that individuals with higher hope were less likely to enter treatment (Jackson, Wernicke & Haaga, 2003). This finding may suggest that individuals with higher hope are able to develop strategies to deal with their difficulties without the help of a therapist; on the other hand, the finding may indicate that those with lower hope are more willing to admit they have a problem that they are unable to handle on their own (Jackson et al., 2003). Although previously discussed studies indicate that counselling leads to increased hope, it appears that initial level of hope may influence one's decision to commence therapy. Overall, hope has been shown to be important in counselling at all stages, including in the decision to take part in treatment.

Physiological evidence of the effects of hope.

Hope has been found to be associated with physiological changes in the body. Udelman and Udelman (1991) found an association between hope and increased serotonin in the brain, which could decrease the likelihood or extent of depression. These authors contend that in light of their findings, treatment of illness should combine both medical treatment and therapy that targets emotions. Gottschalk, Fronczek and Buchsbaum (1993) used PET scans to locate the mental representations of hopefulness and hopelessness within the brain. Gottschalk et al. found that hopefulness and hopelessness result in differential glucose metabolism within separate areas of the brain; although, both hope and hopelessness appear to involve areas associated with cognition, memory, perception and emotion, they appear to be represented in separate locations within the brain. In addition, Gottshalk et al. (1993) argue that these different locations are involved in various psychological states. Therefore, the view that hope and

hopelessness affect one's psychological well-being is supported by the presence of physiological correlates of hope and hopelessness. The research of Udelman and Udelman (1991) and Gottshalk et al. (1993) indicate that evidence of physiological effects of hope have been found, and suggest that it could be beneficial to target hope with therapeutic interventions.

Overall, many researchers have addressed hope and its existence in the counselling context and caregiving relationships. The previously cited literature shows that hope has been described by researchers with a variety of theoretical backgrounds. Because it has been identified as important regardless of theoretical orientation toward psychotherapy, it follows that hope is most likely an important element that is common to all types of psychotherapy.

The Therapeutic Alliance in Counselling

The relationship between client and therapist has been termed the therapeutic alliance, the working alliance or the therapeutic relationship. Although, these terms are often used interchangeably, their meanings can be interpreted slightly differently. The therapeutic relationship can be seen as a broader term, while the therapeutic alliance and working alliance are concepts that refer to a specific part of the relationship derived from research.

Due to the nature of psychotherapy and counselling, it is indisputable that a relationship between a therapist and a client exists; yet, the importance of this relationship to client change was not always accepted. When Rogers (1957) proposed that components of the therapeutic relationship not only led to client change, but were the necessary and sufficient conditions to promote such change, his views were considered

radical at the time. Some of the important components of therapy outlined by Rogers include establishing rapport, and providing the fundamental therapeutic conditions of genuineness, unconditional positive regard and empathy (Rogers, 1957; 1940). Today, these elements are known as the therapeutic triad and are considered essential to psychotherapy. Rogers hypothesised that it is the components of the relationship, such as empathy and genuineness that lead to change, rather than therapeutic techniques. Rogers (1957) proposed that using techniques in therapy is important only insofar as it allows for expression of the relationship components that are necessary for change to occur. Rogers also believed that the relationship and its importance spanned all types of therapies and all types of clients.

Although the relationship has not been shown to account for all of therapeutic change, it has been shown to account for a substantial amount of therapeutic outcome (Horvath & Symonds, 1991; Kivlighan & Shaughnessy, 1995; Martin, Garske & Davis, 2000). As well, the therapeutic relationship and its components, as defined by Rogers and including empathy and unconditional acceptance, has been shown to be related to greater self-esteem and less need for external approval (Cramer, 1993). Hence, Rogers' hypotheses have received partial support. In summarizing the important aspects of the therapeutic relationship as supported by the research literature, Sexton and Whiston (1991) stated that a helpful relationship between client and therapist should include interaction from both parties, and the counsellor should be perceived by the client as displaying empathy, positive regard, warmth and credibility. These attributes are analogous to those described by Rogers (1957). It is also now accepted that the therapeutic alliance is important to treatment success in all forms of therapy (Rogers,

1957; Bordin, 1979; Horvath & Greenberg, 1994; Horvath, 2000; Gelso & Carter, 1994; Luborsky, 1994).

The therapeutic alliance was originally described in psychoanalytic theory. Like Rogers (1957), Bordin (1979) argued that the working alliance is present in all forms of therapy and that a strong alliance is necessary to produce therapeutic change. Bordin (1979) described the alliance as involving a bond between therapist and client, and agreement on the tasks and goals of therapy. The alliance differs in definition from the therapeutic relationship by its emphasis on agreement on therapeutic tasks and goals. Bordin (1979) argued that due to their diverse natures, different types of therapy might produce different kinds of alliances because the various orientations place different demands on therapist and client, and lead to different types of tasks and goals. However, Horvath (1994) observed that there is no direct support for the contention that different types of therapy lead to different types of alliances. Bordin (1994) stated that the bond of the therapeutic alliance develops as a result of working on the shared activities (ie. the tasks) of therapy, and therefore, agreement on the tasks and goals are important in the development of the alliance. It has also been observed that both client and therapist characteristics influence the alliance since these characteristics influence the agreement on tasks and goals (Bordin, 1979). According to Bordin (1994), with clients with mild problems, a strong alliance can be developed in one session, while those with more severe psychological problems require more time to develop the working alliance with the therapist. Bordin's proposition of the importance of the therapeutic alliance (Bordin, 1979) has led to extensive research on the therapeutic alliance from all theoretical orientations.

Gelso and Carter (1994) have further specified the components and important features of the therapeutic alliance. These authors described the therapeutic relationship as consisting of the working alliance, a transference relationship, and a genuine relationship. According to this theory, a strong alliance is associated with little transference and much genuineness. These authors contend that the alliance is not stable over the course of therapy and often declines after its initial establishment, but will later increase if therapy is effective. The instability of the alliance over the course of therapy is due to changes in the amount of transference and genuineness at different times during treatment. Gelso and Carter reiterate Bordin's (1979) proposition of the importance of a strong alliance for therapy to be effective.

In their examination of the structure of the alliance over time, Kivlighan and Shaugnessy (1995) reported that in the beginning of therapy, therapists and clients view the quality of the alliance differently, but as treatment progresses, their ratings of the alliance become correlated. Kivlighan and Shaugnessy (1995) described the development of the alliance from the client's perspective as linear; thus, from the client's perspective, the alliance does not fluctuate over time, as described elsewhere (Gelso & Carter, 1994; Horvath & Greenberg, 1994). That clients' perception of the alliance is linear indicates that establishing a positive alliance early in therapy is important, as the client's view of the alliance may not change from their initial perception. Kivlighan and Shaugnessy (1995) agree with Gelso and Carter (1994) that the alliance is not static throughout treatment; but, similar to the findings of Martin et al. (2000), found that clients tend to view the alliance as stable. Because of the high correlations between alliance ratings at the final therapy session and client reports of treatment success, Kivlighan and

Shaugnessy (1995) suggest that the final alliance rating provides information about the success of treatment.

Importance of the alliance to treatment outcome.

The therapeutic alliance has been found to be a major contributor to therapeutic outcome (Horvath & Symonds, 1991; Kivlighan & Shaughnessy, 1995; Martin et al., 2000). The relationship between therapeutic success and the therapeutic alliance applies to all types of therapy (Bordin, 1979; Horvath & Greenberg, 1994; Luborsky, 1994). While it has been estimated that the therapeutic relationship accounts for 30% of client improvement (Lambert, 1992), other reports indicate that the correlation between the therapeutic alliance and treatment outcome is between .20 and .45 (Luborsky, 1994), which would indicate that the alliance accounts for between 4 and 20 percent of therapeutic outcome. Similarly, in their meta-analysis, Horvath and Symonds (1991) reported an average effect size of the alliance to be .26, a finding that was robust across studies that differed on other variables, such as number of subjects and length of treatment.

Martin et al. (2000) conducted a similar meta-analysis to that of Horvath and Symonds (1991) but included more studies, both published and unpublished. An overall correlation of .22 between alliance and treatment outcome was reported. An examination of the studies that used the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) found the correlation between the WAI and outcome to be .24. Elsewhere, it has been reported that the average correlation between the WAI and therapeutic outcome is .33 (Horvath, 1994).

The relationship between alliance and outcome has been found to be strongest when clients' perceptions of the alliance are used (Horvath & Symonds, 1991; Luborsky, 1994). This does not necessarily indicate that clients are more sensitive in their perceptions of the alliance, but rather, it may be the case that clients and therapists are attuned to different elements of therapy when rating the alliance (Samstag, Batchelder, Muran, Safran & Winston, 1998). That is, the therapist's perception of the alliance may be based in theory, while the client's perception is subjective and based on past relationship experiences (Horvath, 2000). In order for a positive therapeutic outcome to occur, the therapeutic alliance must be developed and established in the early stages of therapy (Horvath & Greenberg, 1994). Luborsky (1994) reported that healthier clients are able to develop stronger alliance with their therapist.

The therapeutic alliance has also been found to contribute to the improvement of specific problems. Barber, Connolly, Crits-Christoph, Gladis and Siqueland (2000) found the therapeutic alliance to be predictive of improvement in depression. More specifically, those patients who improved more over the course of treatment reported a stronger alliance with their therapist and this relationship remained significant even when prior change in depression symptoms was statistically controlled. Thus, the therapeutic alliance continues to be an important predictor of treatment outcome throughout therapy, regardless of previous symptom reduction.

Meyer et al. (2002) found that the relationship between the client's expectation of treatment outcome and actual outcome is mediated by the client's contribution to the alliance. Thus, a client who expects a better outcome from therapy, makes more positive contributions to the alliance, and therefore, achieves greater improvement. The belief that

therapy will produce change is imperative to outcome. The present study may reveal whether clients with higher levels of hope do the same.

It has been reported that clients who were receiving psychological treatment for depression and who reported a more positive therapeutic alliance were more likely to remain in treatment and to have more positive outcomes (Blatt, Zuroff, Quinlan & Pilkonis, 1996). Blatt et al. also explored the influence of client characteristics on the importance of the therapeutic alliance and found that therapeutic outcome was significantly predicted by alliance when the client reported moderate amounts of perfectionism; however, at either high or low levels of client perfectionism, therapeutic outcome was better predicted by perfectionism, rather than alliance. Blatt et al. interpret their results as suggesting that at low levels of perfectionism, clients are able to benefit from therapy regardless of the quality of the relationship, at moderate levels of perfectionism, the relationship contributes to the clients' ability to overcome negative schemas, while at high levels of perfectionism, the quality of the alliance does not reduce the negative effects of perfectionism as much. Thus, clients with differing levels of perfectionism experienced the therapeutic relationship as differing in importance to outcome. Blatt et al. suggest that treatment outcome is the result of an interaction between client and therapist characteristics in the development of the therapeutic alliance. For this reason, Blatt et al. contend that the therapeutic relationship is an important concept to study, rather than comparing different therapeutic interventions.

Therapeutic alliance and treatment termination.

Although, the therapeutic alliance has been found to be related to treatment success, as discussed above, its relationship to the manner in which a client terminates

treatment is inconclusive. The ways in which treatment can be terminated include mutual agreement between the client and therapist to cease therapy after either successful or unsuccessful outcome, or for the client to discontinue treatment without consulting his or her therapist, which is also termed as dropping out of therapy or premature termination. Although some researchers have hypothesised that treatment dropouts do not experience a positive alliance with their therapist, not all have found supporting evidence for this contention.

In their study on treatment failure, Samstag et al. (1998) found that patients who dropped out of therapy rated the therapeutic alliance significantly lower than clients who remained in therapy and reported either good or poor treatment outcomes. In addition, when the therapists rated the alliance, the dropout group had significantly lower alliance scores than the good outcome group, although the scores were not significantly different from the poor outcome group. Thus, the client rated alliance predicted dropping out from treatment, but the therapist rated alliance did not.

In a similar study exploring predictors of premature termination, Kokotovic and Tracey (1990) found that neither variables reported by clients nor those rated by therapists after the first session discriminated those clients who would continue in counselling from those who would not. Kokotovic and Tracey reported that the working alliance did not differ significantly between clients who stayed in treatment and those who did not. As well, although a client's level of adjustment as rated by the therapist was related to the overall working alliance scores, the client self-reports on adjustment were unrelated. Additionally, a client's presenting concerns were generally not related to level of alliance; this contradicts the finding of Luborsky (1994) who found that

psychologically healthier clients develop a stronger therapeutic alliance when in treatment.

The inconsistency in the literature regarding the alliance as a predictor of treatment termination may be related to differences in when and how the alliance is measured as well as a failure to differentiate the clients who terminate treatment prematurely due to dissatisfaction from those who terminate because they feel they have benefited from therapy. Within the alliance literature, strategies to resolve problematic alliances have been suggested; thus, it is possible that conflicting evidence on the relationship between poor alliance and treatment termination appears because some therapists who recognize the poor alliance are able to address the underlying issues in such a way that the alliance improves and the clients remains in treatment (Kokotovic & Tracey, 1990). On the other hand, the literature may be contradictory because the relationship between the alliance and treatment continuation is mediated by another variable. For example, it has been found that clients who continue with counselling differ significantly from those who discontinue prematurely in their satisfaction toward counselling (Kokotovic & Tracey, 1987).

Hope within the therapeutic alliance.

Little has been written on the relationship between hope and the therapeutic alliance. A search of the literature revealed only one unpublished study exploring the contribution of the alliance to the client's hope (Kraatz, 2003).

Kraatz (2003) researched whether the therapeutic alliance, measured from the client's point of view after six counselling sessions, was related to hope, depression and psychological distress prior to counselling and after six counselling sessions. Kraatz

reported a significant increase in hope during the course of therapy, while the participants' depression and psychological distress did not decrease significantly. This finding indicates that a change in hope was not related to changes in depression or distress. Kraatz also reported that the therapeutic alliance, as reported by the client, did not predict an increase in hope, a decrease in depression or a decrease in psychological distress. The findings of Kraatz, that the alliance did not predict treatment outcome, contradicts the findings of other previously cited studies on the therapeutic alliance (e.g. Horvath & Symonds, 1991; Kivlighan & Shaughnessy, 1995; Martin et al., 2000). It is possible that the ability to detect a relationship was reduced because data was collected only twice during the study and because the second measures were taken after only six sessions.

Although Kraatz (2003) did not find a relationship between hope and the therapeutic alliance, limitations in her study and the findings from other studies support further investigation of the relationship. For instance, hope has been theorized as existing within relationships (Farran et al., 1995; Campling, 2002; Herth, 2005). Likewise, Dufault and Martocchio (1985) include an affiliative dimension of hope, and state that the hope of others can influence one's level of hope or encourage one to act on one's hope and describes hope as being present in a relationship. In addition, Helm (2004) has specifically described hope as being part of the therapeutic relationship in psychoanalysis. Based on the theories of Dufault and Martocchio (1985), Campling (2002) and Helm (2004), it is likely that a relationship between the therapeutic alliance and hope does exist. Horvath and Greenberg (1994) described a client's initial approach toward treatment as hopeful and stated that if the alliance is not established, this

hopefulness will dissipate; this suggests that the maintenance of hope and the development of the therapeutic alliance are inherently related. In addition, like the alliance, hope has been found to be related to therapeutic outcome (Irving et al., 2004). The evidence that both hope and the alliance relate to outcome supports an exploration of the relationship between the two.

Bustamante (2001) explored the relationship between hope and the therapeutic alliance with terminally ill patients during their process of dying. Bustamante stated that hope contributed to the therapeutic alliance by providing a direction. The direction of therapy may function as a general goal toward which the therapist and client are working, which is similar to Bordin's (1979) theory of the therapeutic alliance as including an agreement on the goals of therapy.

Some of the variance in the client's rating of the alliance has been found to be related to client psychopathology (McCabe & Priebe, 2003). That is, certain psychological symptoms, such as disordered thoughts and depressive symptoms, were negatively correlated with measures of alliance. It has not been determined whether hope, or lack thereof, is a contributing characteristic. Thus, many questions remain, regarding the relationship between hope and the therapeutic alliance.

Self-criticism

Self-criticism has been reported to be correlated with many psychiatric problems and social difficulties (Blatt, 2004) but much of the research has focussed on its relationship to depression (e.g. Blatt, 2004; Rector et al., 2000; Riley & McCranie, 1990; Zuroff, 1994). Self-criticism is closely related to perfectionism, which has been found to act as a barrier to benefiting from therapy (Blatt et al., 1995) and may be a mediating

factor in therapy outcome (Zuroff et al., 2000). In general, it has been found that counselling clients who are highly self-critical experience less success in therapy (Rector et al., 2000), regardless of the type of therapy provided (Blatt et al., 1995).

Self-criticism includes negative thoughts or statements aimed at oneself. According to Bergner (1995), self-criticism need not be damaging; rather, the intent of criticism and self-criticism is to benefit the individual by informing whether or not a behaviour was effective, and if not, what can improve it. Bergner describes self-criticism as pathological when it damages ones ability to participate in a satisfying manner in work and relationships. According to Bergner, the effects of pathological self-criticism include lowered self-esteem, increased vulnerability to the criticism from others, negative emotional states, ignoring positive attributes, and social withdrawal. Highly self-critical individuals also tend to engage in self-blame (Brown & Silberschatz, 1989; Dunkley, Zuroff & Blankstein, 2003).

Bergner (1995) describes a number of reasons that self-critical persons have difficulty changing that have important implications for counselling. To begin with, the individual may not be aware of his or her self-critical thoughts. Second, self-criticism may serve a purpose for the individual, such as being used as a motivation, albeit an ineffective one, for achievement. As well, self-criticism often leads to self-fulfilling prophecies that confirm the individual's beliefs. Because, as mentioned above, self-critical individuals discount positive attributes, they may have difficulty perceiving evidence that contradicts their criticisms. Bergner describes other reasons for engaging in self-critical behaviour such as individuals not wanting to develop an expectation for something and then having their hopes disappointed. Because these aspects of self-

criticism render change difficult, it follows that self-critical individuals will have more difficulty achieving therapeutic success.

Self-critical perfectionism has been associated with more negative mood states and fewer positive mood states (Dunkley et al., 2003; Mongrain & Zuroff, 1995). While self-criticism does not affect dropout rates in therapy (Rector et al., 2000), Rector et al. demonstrated that it not only affects therapeutic outcome, but a reduction in self-criticism was also related to improved treatment outcomes. While it does not appear that the relationship between hope and self-criticism has been explored, because self-criticism has been described as a component of depression (Blatt, 2004; Rector et al., 2000), it may be indirectly related to hope. Indeed, if an individual feels they are not good enough or cannot be successful, it is difficult to imagine that they may feel hopeful toward a future unknown. In addition, self-criticism has been reported to be positively correlated with hopelessness (Riley & McCranie, 1990); thus, an association with hope likely exists.

Self-criticism has been found to be related to certain personality traits. In women, it is positively correlated with neuroticism, negatively correlated with extraversion and negatively correlated with conscientiousness (Zuroff, 1994). Women's peers also perceived them as neurotic if the women tended to be self-critical (Zuroff, 1994). Zuroff et al. (1983) report that self-critical women are perceived as less likeable. Thus, self-criticism is apparent to others to some degree and can lead to negative evaluations.

The effect of self-criticism on the opinions of others has been studied. Powers and Zuroff (1988) had research participants evaluate their performance and the performance of a confederate in conditions in which the confederate was self-enhancing, self-critical or neutral. It was found that the participants evaluated themselves and the confederate

more highly when the confederate was self-enhancing. Conversely, subjects with a self-critical confederate were more self-critical themselves and rated the self-critical confederate higher than themselves. Overall, the self-critical confederates were evaluated less well than the self-enhancing confederates. In addition, the participants with a self-critical confederate made more positive statements to the confederate during a break from the task and expressed more negative opinions of themselves. While the self-critical confederates were evaluated positively during the experiment, after the experiment participant reports indicated they were perceived as less happy, more depressed and functioning less well as students, employees or dates. Overall, this research indicates that while self-critics tend to elicit positive verbal responses from others, the private responses of others were negative. If these findings hold true during psychotherapy, the therapeutic alliance would likely be affected.

Self-criticism has been shown to predict greater achievement goals and fewer interpersonal goals (Mongrain & Zuroff, 1995) while the related concept of perfectionism has been found to impede the development of relationships (Zuroff et al., 2000). Because, as discussed earlier, the relationship component of therapy contributes to a large portion of therapeutic outcome, it follows that self-critical individuals will have fewer successes in therapy. Bergner (1995) describes effective components of the therapeutic relationship when working with self-critical clients as including such things as expressing to the clients that they are acceptable people, that they are significant people, that they possess the agency and capability to change and can be a collaborator in the therapeutic process. It is noteworthy that these components are effective components of all therapeutic relationships, not just those with self-critical clients. Bergner states that therapists should

not view self-critical clients differently, but need to express their acceptance and the other relational components more directly. Importantly, Bergner describes the therapeutic relationship as a necessary intervention with self-critical clients, as it provides a corrective experience; however, it may be more difficult for self-critical clients to develop a strong therapeutic relationship.

Perfectionism, the setting of very high standards for oneself, is related to self-criticism as perfectionists may be highly self-critical when they do not attain the standards they set. Perfectionism has been shown to affect the therapeutic alliance. Zuroff et al. (2000) found that among highly perfectionist clients the therapeutic alliance did not increase or increased only slightly over the course of therapy and the clients' contribution to the alliance did not increase during therapy. That is, perfectionist clients did not become adequately involved in therapy even though they felt as valued by their therapists as other clients did. Zuroff et al. give several reasons as to why perfectionist clients did not contribute to the therapeutic relationship, including their difficulty in developing relationships, needing a longer time to develop strong relationships, or a difficulty in working through alliance ruptures. Zuroff et al. also reported that the negative relationship between perfectionism and outcome could be partly explained by the perfectionists not developing a strong therapeutic alliance.

Overall, the above literature shows that self-criticism and perfectionism do affect counselling outcome and the therapeutic alliance. While it does not appear that its relationship to hope has been explored, certain difficulties associated with self-criticism may also make it difficult for self-critical individuals to develop and maintain hope. Mainly, difficulties in developing positive relationships, more negative moods, and

discounting positive attributes would impinge on the development of hope in many of the dimensions described by Dufault and Martocchio (1985), including the affective, affiliative, and cognitive dimensions. The temporal dimension of hope may also be affected if the self-criticism has been pervasive and enduring, which could in turn, influence the behavioural realm of hope. An exploration of the relationship between hope and self-criticism may answer whether they are truly incompatible.

The Common Factors Model of Therapy

Hope and the therapeutic alliance are variables that fall within the common factors model of psychotherapy. Client variables, such as self-criticism, can also be considered common factors as they are not specific to a certain type of treatment. The common factors model of psychotherapy states that despite theoretical orientation, it is the common elements within all types of therapy and therapy techniques that lead to change and therapeutic success (Lambert, Garfield & Bergin, 2004). Lambert et al. (2004) report that overall, therapeutic techniques have not been shown to produce unique effects; that is, specific techniques do not appear to contribute significantly to therapeutic outcome. Similarly, Sexton and Whiston (1991) report in their review of the literature that research evidence does not support client outcome being related to specific theoretical counselling models. Likewise, Luborsky et al. (2003) reported in their summary of literature that the differences between treatment outcomes of different orientations toward therapy are not significant. Luborsky et al. (2003) suggest that when differences are found between treatments, they are due to chance factors. The above research suggests that the success of therapy is attributable to other elements that operate across all forms of therapy; these elements have been termed common factors.

In support of the common factors view of psychotherapy success, Gershefski, Arnkoff, Glass and Elkin (1996) found that in spite of the specific treatment depressed clients received, the most commonly reported helpful elements within therapy were elements that are common in all types of treatment. These authors found that treatment groups differed only in their reports of elements that are specific to a particular type of treatment, not in their reports of the helpfulness of the common elements of therapy.

Hope has been proposed as a non-specific factor common to all systems of counselling (Snyder, Michael & Cheavens, 1999). Snyder et al. reason that because most change occurs in the early part of therapy, the change is likely not due to specific techniques, but rather, common factors. More specifically, and in line with the hope theory proposed by Snyder, these authors contend that therapy is effective because it leads to either an increase in one's sense of agency, a renewal of one's goals or new goals, or a new pathway toward one's goals, which in turn, increases the client's level of hope. Extrapolating from Snyder et al., it follows that any system of therapy may effectively increase a client's hope, and therefore be an effective form of therapy.

Barker, Funk, and Houston (1988) conducted a meta-analysis to determine the effect of non-specific factors in therapy, by comparing studies that compared a psychological treatment to a non-specific factors control group. The aim of the analysis was to determine whether active treatment has an effect beyond the effect of the factors that are common across therapies, when treatment expectation is similar between groups. These authors found less than half of the total treatment effects were due to non-specific factors and therefore conclude that psychological treatment is more effective than non-specific factors conditions. Interestingly, these results did not hold true at follow-up;

rather, the differences among the treatment conditions and non-specific factors conditions were smaller at follow-up, while the differences between the non-specific factors condition and no treatment were larger at follow-up. Barker et al. suggest the change from post-test to follow-up may indicate that individuals in the non-specific factors group continue to improve after treatment has ended. Thus, although the non-specific factors were not found to produce as large an improvement by the end of treatment, these factors continue to have an effect which becomes visible at follow-up. In summary, although Barker et al. found psychological treatment produced greater change than non-specific factors, this gap closed somewhat by follow-up, and non-specific factors were nevertheless seen to contribute to outcome at follow-up.

In contrast to the findings of Barker et al. (1988), a more recent meta-analysis found no significant differences between full treatments, and treatments which excluded the theoretically crucial elements (Ahn & Wampold, 2001). Overall, Ahn and Wampold found no evidence that the specific elements of different therapies, which are proposed to be the basis of change, do in fact lead to change. Moreover, these authors found that among the 27 treatment comparisons included in their meta-analysis, the effect sizes were not significantly different. The results of Ahn and Wampold suggest support for the common factors theory of psychotherapy.

In their study of the therapeutic alliance and client characteristics in clients diagnosed with depression, Blatt et al. (1996) found that the therapeutic alliance did not differ among clients receiving two different types of therapy: interpersonal therapy and cognitive behavioural therapy. These findings support the position that the therapeutic alliance is an important contributor to therapeutic outcome, regardless of type of therapy.

Because their results were true across different types of therapy, the findings of Blatt et al. also support the common factors view of therapy.

In contrast to the contentions of both the common factors model of therapy and specific theoretical orientations to counselling, Beutler and Harwood (2002) write that both specific interventions and common factors, such as the therapeutic relationship, account for similar amounts of variance in treatment outcome. According to these authors, the effects of common factors generally, and the therapeutic alliance specifically, cannot be separated from the specific therapeutic practices used.

Although, full support for the common factors model of therapy has not been achieved, it has been shown that common factors are effective elements of psychotherapy. The present study is a further exploration of the relationships among several common elements in psychotherapy.

Hypotheses

Based on the above review of the literature, several hypotheses regarding hope, the working alliance and self-criticism were developed. It is expected that:

1. Hope scores will increase during counselling.
2. Working alliance scores will increase during counselling.
3. Psychological symptoms will decrease during counselling.
4. Hope scores will be positively correlated with alliance scores.
5. The correlation between hope and the therapeutic alliance will be stronger when the degree of psychological distress is partialled out from the relationship.
6. Self-criticism will be negatively correlated with hope.

7. Self-criticism will be negatively correlated with alliance scores.

Summary

Research on hope indicates that it increases over the course of counselling and that hope is positively related to therapeutic outcome (Irving et al., 2004). In addition, many hope theories contain a relational aspect of hope (Campling, 2002; Dufault & Martocchio, 1985; Helm, 2004), which supports the investigation of the relationship between hope and the therapeutic alliance. Furthermore, some alliance theorists indicate that hope is present during the initial stages of therapy, and may change depending on whether a strong alliance develops (Horvath and Greenberg, 1994). Overall, although few studies have taken into account both the alliance and a client's level of hope, aspects of the theories behind the concepts of the alliance and hope suggest that these two counselling components may be related. Because a client's level of self-criticism and perfectionism has been found to negatively influence counselling success (Blatt et al., 1995; Blatt et al., 1996, Rector et al., 2000; Zuroff et al., 2000) an exploration of its influence on the other study variables, which have both been reported to be beneficial elements of counselling, is warranted in order to understand its role in counselling.

CHAPTER III

Methodology

The study was conducted in a naturalistic setting at a university clinic that trains graduate students in counselling. The clinic offers individual therapy, couples counselling, family counselling and play therapy as well as psychological and educational assessments to individuals of all ages.

Westen and Morrison (2001) noted that because most potential participants are excluded from participating in research studies related to the effectiveness of therapy, the generalizability of the results of such studies is unknown for clinicians who are unable to choose their clients. These authors found a relationship between the number of potential participants that were excluded from a study and the number of participants who improved due to treatment, suggesting that improvement is more visible when the study sample is homogenous. However, because few clinicians work with a homogenous population, it is currently unknown whether the therapies tested in research laboratories are in fact better or worse than the therapy practised by therapists in clinics (Westen & Morrison, 2001). That research participants presented with multiple and diverse issues for counselling and were not screened on the basis of these issues represents a strength of this study because the study population is more likely representative of a typical outpatient counselling population.

Participants

Potential participants included all adults 18 years and older who sought individual counselling at the Education Clinic, at the University of Alberta between September 2004

and April 2005. All adults seeking individual counselling were approached for participation, regardless of presenting issue. During the course of the study, 196 people presented to the clinic for counselling. Of these, 105 clients were adults seeking individual counselling. Of the 105 clients who were invited to join the study, 67 agreed to participate. The therapists were seven doctoral students and eight Masters' level students who were each supervised by experienced chartered psychologists.

Participants ranged in age from 18 to 62 years old, with the mean age being 35.5 years. The majority of participants (69%) were female, while 31% were male. Most participants were self-referred to the clinic (52.2%); other participants were referred by a physician (14.9%), an agency (9%) or "other" (23.9%), usually described as being a friend, family member, or the media. An overwhelming majority of clients identified themselves as Caucasian (88.1%) while 7.5% of clients identified being of Mixed Ethnicity, one client self-identified as Asian and one client as East Indian. Of the 64 participants who described their marital status, 28.4% reported being single, 37.3% reported being married or having a common-law partner, 26.9% of participants reported being divorced or separated, while 3% reported being widowed. Participants came from diverse income brackets ranging from a total household income of less than $10,000 per year, to over $50,000 per year. Participants were fairly evenly distributed across six pre-defined income categories, which were: less than $10,000; $10,000- $20,000; $20,000- $30,000; $30,000- $40,000; $40,000- $50,000; and $50,000 or more. Educational level ranged from a high school diploma to graduate degrees. Analysis of variance and chi-square revealed no significant differences on the aforementioned variables among clients who chose not to participate in the research when compared to clients who did

participate; thus, the study participants were representative of the adult population seeking counselling at this clinic.

While initial response to participate in the study was satisfactory, each phase of the study contained fewer participants. The study started with 67 participants, then 43 participants completed the instruments at session 5, and 32 participants completed the instruments at counselling termination. Thus, the dropout rate from session one to session five was approximately 36%, and by termination, 52% of initial participants did not complete the study.

Because of the dropout rate of the study, analyses were conducted prior to the testing of hypotheses to determine whether non-completers were significantly different from completers on the measured demographic variables. Analysis of variance indicated that completers and non-completers did not differ with regards to age, while chi-square indicated no significant difference based on gender, ethnicity, referral source, marital status, education, and household income. ANOVAs additionally indicated no significant differences between study completers and non-completers on the initial measures of hope, the working alliance, self-criticism and psychological health. A significant difference for number of counselling sessions was found, however; analysis of variance indicated that those participants who completed a termination package received more counselling sessions that those who did not ($F=11.809$, $p<.01$). On average, those participants who completed the study took part in 13 sessions, while those participants who did not complete the study averaged 7 counselling sessions.

The results of the analysis of variance and chi-square showed that the study sample was not different on the demographic variables from non-participants who

attended the clinic for counselling. Apart from the total number of counselling sessions, it appears that those who did complete the study were also representative of the original study sample.

Instruments

To measure the study variables, four self-report measures were used. Hope was measured with the Herth Hope Scale (HHS; Herth, 1991), the alliance was measured with the Working Alliance Inventory, Short Form (WAI; Horvath & Greenberg, 1989) psychological health was measured using the General Health Questionnaire (GHQ; Goldberg & Hillier, 1979) and the self-criticism scale of the Depressive Experiences Questionnaire (DEQ; Blatt, D'Afflitti & Quinlan, 1976) provided the measure self-criticism. Although, self-criticism was not an original study variable, the DEQ was being used for a concurrent study with the same clients, so the self-criticism data was included for an exploratory analysis. As will be explained in the procedures section, participants completed four self- report measures at session 1, two self-report measures at session 5 and three at counselling termination.

The Working Alliance Inventory.

The WAI was developed to measure the therapeutic alliance across all types of therapy (Horvath, 1994). Tracey and Kokotovic (1989) conducted confirmatory factor analysis to determine which of three proposed models best describes the factor structure of the WAI. These authors conclude that a bi-level model was the best fit for the data. The bi-level model describes the WAI as measuring an overall alliance measure and three factors based on Bordin's (1979) definition of the therapeutic alliance: the bond between

the therapist and client, agreement on tasks and agreement on therapeutic goals. Using the results of their study, these authors also formed the WAI-Short, a condensed version of the WAI, by assembling the four highest-loading items on each of the three WAI subscales, to obtain a 12 item measure of the therapeutic alliance. Similar to the original 36 item version of the WAI, the shortened version is reported by Tracey and Kokotovic to fit in their proposed bi-level model, by measuring one overall alliance factor, and the three factors of the alliance put forth by Bordin. Tracey and Kokotovic also report that the internal consistency of the WAI-S is satisfactory. These authors suggest that the subscale scores should be used with multivariate statistics, and univariate tests should involve only the general alliance factor.

Busseri and Tyler (2003) compared the WAI to the WAI-S. Both measures were found to have high internal consistency, the subscales of each form were found to intercorrelate highly as did the overall alliance rating from each test. Subscale and total scores from each were found to have similar descriptive statistics. Furthermore, Busseri and Tyler found the predictive validities of both the WAI and the WAI-S to outcome variables to be comparable. These authors suggest their results support the validity and reliability of the WAI-S and conclude that the WAI-S can be used in place of the longer WAI. Based on these findings, the WAI-S was chosen for the present study to reduce participant fatigue. Each item on the WAI-S is based on a 7-point likert scale; thus, the highest attainable score is 84 while the lowest possible score is 12.

Herth Hope Scale.

The Herth Hope Scale (HHS; Herth, 1991) is a 30 item self-report measure of hope based on the theory of hope put forth by Dufault and Martocchio. The HHS is

scored on a 4-point likert scale with the low end of the scale represented by 0 and the high end by 3. The lowest possible score on the HHS is 0 while the highest is 90 and a higher score is indicative of higher hope. The instrument was validated on a wide range of adults including healthy adults, a group of elderly individuals living in the community, a group of elderly widows and a group of adult cancer patients. The scale's internal consistency, test-retest reliability and discriminant validity are all high, which supports its use. Factor analysis (Herth, 1991) indicates adequate construct validity and three factors that are consistent with the six dimensions of Dufault and Martocchio's (1985) model of hope. The factors are also the subscales of the HHS. The first subscale is labelled Temporality and Future and it is said to measure the cognitive and temporal dimensions of hope. The Positive Readiness and Expectancy subscale is said to measure the affective and behavioural dimensions of hope, while the Interconnectedness subscale measures the affiliative and contextual dimensions of hope.

The General Health Questionnaire.

The General Health Questionnaire- 28 (GHQ; Goldberg & Hillier, 1979) is a 28 item self-report instrument that provides an overall index of health, and 4 subscales that measure anxiety and insomnia, depression, somatic symptoms and social dysfunction. It is based on an earlier 60 item version of the GHQ. Although there is some correlation between subscales, this correlation reflects the general factor that was found to account for 35% of the variance in the original analysis (Goldberg & Hillier, 1979). Goldberg and Hillier (1979) found that the 28 item GHQ accounted for 59% of total variance in one sample and 53% and 58% of the variance when the analysis was replicated with two other samples. When the factor structure of the GHQ-28 was analysed more recently, it

was found that the factors were relatively stable across countries as compared to the original analysis (Werneke, Goldberg, Yalcin and Ustun, 2000). Like the HHS, the GHQ is scored on a 4-point likert scale with 0 to 3 points being awarded. The lowest possible total score is 0 while the highest is 84. High scores indicate many psychological symptoms were reported, while low scores indicate fewer symptoms and better psychological health.

The Depressive Experiences Questionnaire.

The Depressive Experiences Questionnaire (DEQ; Blatt, D'Affitti & Quinlan, 1976) is a 66 item self-report instrument meant to measure an enduring vulnerability to depression, rather than symptoms of depression. Factor analysis in the original validation sample revealed three factors. The three factors, which are also the three scales of the DEQ are dependency, self-criticism and self-efficacy. Split-half reliability indicates the factor structure is stable (Blatt et al., 1976) and the factors have been shown to be stable across time (Zuroff et al., 1983), which indicates the scales measure fixed traits. The dependency and self-criticism scales are reported to have moderately strong internal consistency in a normal population (Viglione, Clemmey & Camezuli, 1990) and acceptable construct validity in clinical populations (Riley & McCranie, 1990). Each item of the DEQ is based on a 7-point likert scale. The scoring of the DEQ is complex because items are weighted differently, so a computer program is required. Standard scores are derived from norms and an individual's score is expressed as a deviation from the norm. For the purposes of this study, only the data from the self-criticism scale were used.

Procedure

Consent for participation was sought by each client's therapist at the beginning of the initial counselling session, at which time written consent was obtained for those who chose to participate (see Appendix A). An overview of the project was provided to all participants (see Appendix B). Participants were informed that they were under no obligation to participate and could withdraw from the study at any time. Participants were informed that personal information and responses from the study would not be shared with their therapist; thus, confidentiality was ensured. All participants were assigned a research number for identification purposes and the completed forms were placed in sealed envelopes in a locked box so as to not be seen by the participants' therapists. Participants did not receive compensation for taking part in the study.

The Herth Hope Scale, DEQ and the GHQ were first completed prior to the first session as part of the clinic intake package, while the WAI was completed after the first session if the client consented to participate in the study. The HHS and WAI were completed after session 5, and the HHS, WAI and GHQ were completed at the client's final counselling session.

Statistical analysis

Data was compiled and analysed using SPSS 11.0. All comparisons were planned and designed to answer the research questions. Thus, to examine whether hope and the alliance each increase as therapy progresses, correlation coefficients for sessions one, five and termination of the HHS were calculated, as were the correlation coefficients of the WAI at sessions one, five and termination. The correlation between the WAI and the HHS was calculated to determine whether there is a relationship between these two

variables, and finally, the correlation between the WAI and the HHS was calculated with the measure of psychological distress partialled out. The self-criticism scale of the DEQ was correlated with the HHS, the WAI and the GHQ. Repeated measures ANOVA was used to compare the mean scores of the HHS and the WAI at the three data collection times, to obtain an understanding of the overall trend of these variables during the study. While the data from all the participants was used for the correlational analyses, when calculating Repeated Measures ANOVAs, only the data from the participants who completed the study were used. For all analyses, a cut-off of $p<.05$ was chosen for the level of significance, as is routine in the social sciences to balance the effects of Type I and Type II error.

CHAPTER IV

Results

The focus of this section is the statistical analysis of the data obtained. The analysis for each hypothesis will be described, as will whether or not the hypothesis received support. Not all of the hypotheses were statistically supported, but it is unclear whether this is due to unanticipated results, or because of loss of power due to participant dropout rates.

Hope During Counselling

Hypothesis 1 was that hope would increase during counselling. The means of the Herth Hope Scale at Time 1 (initial session), Time 2 (session 5) and Time 3 (termination session) for the study completers were compared using repeated measures ANOVA. The means and standard deviations for the study completers and the full sample are presented in Table 1. A linear model was found to be significant ($F=24.594$, $p<.001$) for the study completers. Contrasts were conducted to determine which means were significantly different and it was found that all means were significantly different from each other. Hope increased significantly at each measurement time as compared to the previous measurement time; thus, hypothesis 1 was supported.

Table 1

Mean Scores on the Herth Hope Scale

	Session 1	Session 5	Termination
Study Completers	60.157 (16.663)	65.500 (14.347)	71.109 (15.622)
	n= 23	n= 23	n= 23
Full Sample	59.0434 (15.396)	64.636 (12.909)	71.726 (14.235)
	n=67	n= 43	n= 31

Note. Standard deviations are in parantheses.

Working Alliance During Counselling

Hypothesis 2 was that the working alliance scores would increase during counselling. Repeated measures ANOVA was used to compare the means of the Working Alliance Inventory at the three measurement times for study completers. The linear model described the data slightly better than the quadratic model ($F= 6.488$, $p<.05$). The means and standard deviations are presented in Table 2. Contrasts indicated that for study completers, while the mean at Time 1 is significantly different from the means at Time 2 and Time 3, the difference between the Time 2 and Time 3 means are not different. Thus, while the alliance, as perceived by the client, increased from the session 1 to session 5, it did not change significantly from session 5 to the termination session. Hypothesis 2 was supported as the working alliance did increase from session 1 to session 5, but the increase did not continue after session 5.

Table 2

Mean scores on the WAI

	Session 1	Session 5	Termination
Completers	65.773 (9.670)	72.273 (8.542)	71.864 (9.770)
	n=22	n= 22	n=22
All Participants	66.175 (9.478)	70.878 (9.125)	70.978 (9.129)
	n= 59	n= 41	n= 32

Note. Standard deviations are in parantheses.

Psychological Health

Hypothesis 3, that an analysis of the GHQ scores would indicate an increase in psychological health, also received support. A paired samples t-test was used to determine whether psychological health, as measured by the General Health Questionnaire, improved during counselling. Based on the 32 participants who completed the GHQ at the initial session and at termination, the mean GHQ score at the initial session ($\bar{x}$= 26.563, SD= 15.145) was higher than the GHQ score at the termination session ($\bar{x}$= 16.719, SD= 9.045). This difference was significant (t= 4.063, p<.001), indicating that reported symptoms decreased and psychological health improved during counselling. The means also indicate that although symptoms decreased, they did not disappear completely.

Relationship Between Hope, the Alliance and Psychological Health

Table 3 shows the correlation coefficients between the HHS, the WAI and the GHQ at the 3 data collection times. Hypothesis 4, that the hope scores will be positively

correlated with the working alliance scores received only partial support. Hope was only significantly correlated with the working alliance at the session 5 measures. At session 1 and termination, hope and the alliance were not significantly related.

Table 3 also shows that the GHQ, which measures psychological health, was negatively correlated with some of the hope scores. More specifically, the initial measure of psychological health at session 1 was negatively correlated with hope scores at session 1 and 5, but not the termination session. Psychological health at termination was negatively correlated with session 1 and termination hope scores. The negative sign of the correlation coefficients signifies that higher hope was associated with fewer psychological symptoms. The GHQ was not found to be significantly correlated to the working alliance at any of the data collection times.

Table 3

Intercorrelations Between the GHQ, HHS, and WAI at Session 1, Session 5 and Termination

		Session 1			Session 5		Termination		
		GHQ	WAI	HHS	WAI	HHS	GHQ	WAI	HHS
Session 1	GHQ		.031	-.507*	.032	-.502**	.450**	.123	-.316
	WAI			.100	.477**	.039	.030	.401*	.089
	HHS				.226	.809**	-.412*	-.082	.784**
Session 5	WAI					.387*	.064	.323	.047
	HHS						-.400	-.148	.811**
Termination	GHQ							-.062	-.534**
	WAI								.082
	HHS								

*p<.05. **p<.01.

Hypothesis 5, that the relationship between hope and the alliance would become stronger when the influence of psychological health was removed was explored by calculating the partial correlations between the WAI and the HHS. When the initial GHQ score was partialled out, the correlation between the alliance and hope at session 5 was no longer significant (partial r= .295, p= ns); the same is true when the GHQ at termination was partialled out (partial r=.322, p= ns). None of the partial correlation coefficients between the WAI and the HHS at any of the sessions were significant.

Self-criticism

Hypothesis 6 and 7 were that self-criticism would be negatively correlated with measures of hope and the working alliance, respectively. Self-criticism was measured by the DEQ prior to beginning session 1. Table 4 shows the correlation between self-criticism and the measures of hope, the alliance and psychological health. While self-criticism was related to both hope and the initial measure of psychological health, it was not significantly related to the working alliance or psychological health at termination. Thus, hypothesis 6, but not 7, was supported. Overall, participants with higher levels of self-criticism reported lower levels of hope at session 1 and session 5. This relationship was quite strong, with over 30% of the variance explained by the relationship, but the relationship was no longer statistically significant by treatment termination. The correlation between self-criticism and the GHQ shows that participants with higher self-criticism also presented to counselling with more psychological symptoms. While the early measures of hope and psychological symptoms were significantly correlated with self-criticism, termination measures were not correlated with self-criticism. Because self-criticism was measured only once, it is unclear what factors contributed to the loss of

significance of the correlations of self-criticism with hope and psychological health by counselling termination.

Table 4

Correlations Between Self-Criticism and the GHQ, WAI, and HHS

Session 1			Session 5		Termination		
GHQ	WAI	HHS	WAI	HHS	GHQ	WAI	HHS
.597**	.098	-.551**	-.154	-.561**	.186	.318	-.140

*p<.05. **p<.01.

To determine whether self-criticism influenced the relationship between hope and the therapeutic alliance, partial correlations were calculated controlling for the effect of self-criticism. When this was done, no significant partial correlations were found between hope and the working alliance.

Summary

The statistical analysis yielded both expected and unexpected results. As expected, both hope and the working alliance increased significantly during counselling. Clients also showed reduced symptoms of psychological distress. Unexpectedly however, the hypothesis that hope and the alliance would be related received only partial support, as it did not hold true throughout counselling. A positive correlation was obtained only between the session 5 measures of hope and the alliance and this correlation was no longer significant once the measure of psychological health was partialled out. Thus, the respective increases in hope and the alliance during counselling were relatively independent of one another. Self-criticism was found to be strongly related to clients' hope in that highly self-critical individuals reported lower levels of hope. Meanwhile,

self-criticism was not correlated with clients' perception of the alliance, contrary to what was hypothesised. The meaning and implications of the above results will be explored in the next chapter.

CHAPTER V

Discussion

The results of the analysis indicate that hope increased significantly during the course of counselling, while the working alliance increased significantly between session 1 and 5. Hope and the working alliance were not significantly correlated with one another, which was an unexpected result. Self-criticism was related to hope but not the alliance. While some of the study findings are consistent with past research, others are not. In this section, the consistencies and inconsistencies of the results with previous research will be examined and the present findings will be integrated with previous research. The implications of the findings for future research and counselling practice will be discussed.

The Importance of Hope

As hypothesised, hope was found to increase over the course of counselling. The trend was linear; thus, at each data collection point, hope was significantly higher than at the previous measurement time. This finding is important in several ways.

First, while some authors have proposed that hope is an important element in counselling (Edey & Jevne, 2003; Irving et al. 2004; Snyder et al., 1999; Snyder et al., 2000), they have either not measured hope quantitatively, or measured hope as defined by Snyder et al. (1991), which, as previously discussed, is a more narrow conceptualisation as compared to the definition of hope used by other researchers (e.g. Dufault & Martocchio, 1985; Farran et al., 1995). The present research measured hope with the Herth Hope Scale (Herth, 1991), which measures hope in a way that covers the

definitions of both Dufault and Martocchio (1985) and Farran et al. (1995); thus, both specific and global aspects of hope were captured by the measurement. While in the past it has been shown that Snyder's conceptualisation of hope contributes to counselling outcome (Irving et al., 2004) and increases during counselling (Kraatz, 2003), the present research indicates that hope can be shown to increase when other aspects of hope are measured, such as its temporal, affiliative and affective dimensions. In other words, in addition to the cognitive aspects of hope that have been found to increase during counselling, the present research suggests that hope across time, within relationships, and as an emotion also increase.

The finding that global, non-specific hope increases during counselling as well as more specific aspects of hope is important because previous research has not yet shown this. The implication is that participating in counselling is related to an increase in an individual's overall hopeful outlook, not just their hope as related to personal goals or the issues for which counselling was sought. Thus, counselling may have a more global effect that is not necessarily specific to the expectations the client brought to counselling. That hope was found to increase throughout counselling indicates that it is important during the entire counselling process. It is possible that the increase in the global aspect of hope partially accounts for the long-term effectiveness of psychotherapy.

In the present study, the hope scores of those participants who did not complete the study were not significantly different from the scores of those participants who did complete the study, even though hope was found to increase significantly at each measurement time. This indicates that hope is not likely responsible for issues of premature termination. This also suggests that hope increases for all counselling clients,

not just those who remain in treatment for longer periods of time; thus, an increase in hope likely occurs in both brief psychotherapies and longer forms of therapy.

Similar to the study of Irving et al. (2004), the present findings indicated that hope was related to psychological health. More specifically, those participants who reported fewer psychological symptoms also reported higher levels of hope. This finding is correlational, thus a cause and effect relationship cannot be posited; however, it suggests that increasing hope can be considered an important treatment goal for counselling due to its relationship to increased psychological health and fewer symptoms. The finding also indicates that an increase in hope may be an indication of effective treatment. Therefore, measuring hope both during counselling and as an outcome measure may shed light on the effectiveness of therapy. Overall, this study has shown that hope is an inherently important aspect of counselling even when more global aspects of it are measured. It has also shown that despite concerns that the diverse understandings of hope may make it difficult to measure (Eliott & Olver, 2002), it is still possible to study the effects of hope in a quantitative manner.

The importance of hope in counselling as measured here provides further support for the view that hope is a factor that is common to all types of counselling (Snyder et al., 1999) for two reasons. First, the finding that hope is important to counselling was replicated and hope is therefore beginning to show itself as important across a number of studies (e.g. Edey & Jevne, 2003; Irving et al., 2004; Kraatz, 2003). Second, while therapists in the present study did not report their theoretical orientation, it should be noted that the students study within a program in which openness toward all theoretical orientations, including eclecticism, is practiced, and the university department does not

subscribe to a specific orientation; thus, it is likely that the student therapists identify with a number of orientations.

Hope has been found to be related to better overall well-being and fewer psychological symptoms (Irving et al., 2004). This relationship held true in the present study, particularly for sessions 1 and 5. This supports the notion of Snyder et al. (2000) that hope can serve as a protective factor. Whether hope is protective due to changes in behaviour and goal attainment, as claimed by Snyder et al. (2000) cannot be assessed with the present results. However, the importance of hope to psychological well-being is suggested by the present results.

Although, it has not been determined by this research how both global and specific aspects of hope increase with counselling, previous research may shed light on this issue. Both Nunn (2005) and Averill and Sundararajan (2005) contend that hope exists only within uncertainty. If an event or goal is either completely improbable or absolutely certain, hope will not be present (Averill & Sundararajan, 2005). Similarly, Nunn (2005) proposes that hope can change as a result of a change in beliefs, desires or judgements; such changes often occur during counselling. It is possible that by changing maladaptive cognitions, such as those that are absolutist or inaccurate, therapy opens a space for uncertainty, and therefore, hope.

The Working Alliance

The working alliance was found to increase from session 1 to session 5, but it remained stable from session 5 to the termination session. This finding was not surprising given that previous research has suggested that once the alliance is established, the client's perspective of it remains stable (Kivlighan & Shaugnessy, 1995; Martin et al.,

2000). Although, the presence of a ceiling effect may also explain why the working alliance was not found to increase after session 5, previous research gives greater strength to the argument that clients tend to report a stable alliance during treatment. The working alliance was also found to be linear without fluctuations, similar to the findings of Kivlighan and Shaughnessy (1995) and Martin et al. (2000), even though other authors have reported that the working alliance fluctuates during counselling (Gelso & Carter, 1994; Horvath & Greenberg, 1994). Possible reasons that the results of this study support a stable view of the alliance are that the alliance was measured from the client's point of view and the working alliance was measured three times during the study, as opposed to after every session. The linear view of the alliance found in the present study supports the contention that it is important for the alliance to be established early on in therapy (Horvath & Greenberg, 1994) because the client's view of the alliance may not change after the initial stage of therapy when the alliance is established.

While previous studies suggest that the therapeutic alliance predicts symptom improvement in depression (Barber et al., 2000; Blatt et al., 1996) and that healthier clients are able to develop a stronger therapeutic alliance (Luborsky, 1994) the results of the present study are not consistent with these previous reports. At no time during the study was the GHQ found to be significantly correlated with the WAI. However, this finding is consistent with that of Kokotovic and Tracey (1990), who also reported that a client's presenting concerns were unrelated to the strength of the alliance. It may be related to the suggestion of Kokotovic and Tracey that when a therapist perceives a weak alliance, he or she may take steps to resolve the issues contributing to the poor alliance. Thus, if the alliance is successfully strengthened, the negative effects of a weak alliance

may be countered. For this reason, it is possible that the alliance may sometimes be found to be unrelated to certain psychological symptoms. On the other hand, if the relationship between the alliance and psychological symptoms is mediated by other variables or is weak, more research participants or a more homogenous population than in the present study would be required in order to detect the relationship.

Unlike the report of Samstag et al. (1998), the working alliance was found to be unrelated to whether or not the participants completed the study. Study completion was not found to be associated with any of the demographic or study variables, including the alliance and hope, which may be reflective of a number of things. First, it may simply be that study completion was not related to these variables in this population. Second, the opposing results of Samstag et al. as compared to the results obtained here may be due to the naturalistic, unscreened sample used in the present study. In other words, selection criteria were not used for the present study, whereas several criteria were employed by Samstag et al, which may have led to differing results. Conversely, it may be that because information was not collected on whether counselling termination was a mutual decision between therapist and client due to attainment of treatment goals or whether the client terminated prematurely, the results were confounded by the type of termination.

Clarification of type of termination may have led to different results. The study method relied on the clinicians to ensure the data collection was executed; thus, although some data may be missing due to clients dropping out from counselling, other data may be missing due to therapists not ensuring that the clients completed the self-report measures at the appropriate times, which may have also confounded the analyses related to the termination measures. In essence, it is unknown how many of the study non-

completers also dropped out of counselling and how many simply did not complete data collection, while continuing in counselling. As well, it is unknown whether ruptures in the alliance were dealt with in a fashion that led to its improvement and/or treatment continuation (Kokotovic & Tracey, 1990), thereby confounding the data and making it difficult to measure whether the working alliance was associated with completion of counselling. At the same time, because previous research (Kokotovic & Tracey, 1990) found that the working alliance was not related to whether a client stayed in counselling, another variable that was not measured may mediate the relationship between the working alliance and treatment termination. Overall, because many of the reasons for study incompletion are unknown, it is difficult to integrate with previous research findings the result that the working alliance was unrelated to study incompletion.

Symptom Improvement

Although it was found that psychological health, as measured by the GHQ, improved, psychological symptoms did not completely disappear. This is consistent with outcome research (Westen & Morrison, 2001) in which participants were found to have reduced symptoms, but continued experiencing symptoms, nonetheless. Westen and Morrison reported that studies using homogenous populations have better treatment outcomes. Because participants in the present study came from a naturalistic population and were not screened prior to participating, it is not surprising that they were not symptom-free upon termination of counselling. In addition, although the present study did not impose a treatment length, with ten sessions being the average treatment length, counselling was relatively brief. It is possible that longer treatment or a homogenous study sample may have resulted in a different pattern of symptom reduction.

The Relationship Between Hope and the Alliance

While hope has been suggested to be present within relationships (Dufault & Martocchio, 1985; Farran et al., 1995; Campling, 2002) and to be within the therapeutic relationship (Helm, 2004) the findings of the present study indicate that although both are within counselling, they are not dependent on one another. As in Kraatz (2003), the therapeutic alliance was found to be uncorrelated with hope even though the mean number of sessions of participants was higher than the six sessions included by Kraatz. At the same time however, both hope and the alliance were found to increase during counselling. This finding suggests that while hope and the alliance are not correlated, both are important to the counselling process. That is, while hope and the alliance co-exist, they are not actually associated. This implies that even though hope may occur within a relationship (Campling, 2002; Dufault & Martocchio, 1985; Farran et al., 1995) the strength of the relationship does not necessarily influence the level of hope that exists. This is consistent with Bustamante (2001) who suggests that hope provides a direction for the alliance; thus, hope may be part of the alliance or co-exist with the alliance, but does not actually influence change within the alliance.

Although, it is possible that a relationship between hope and the alliance was not found due to ceiling effects on the WAI that led to a lack of variation in the scores, the results are consistent with those of Kraatz (2003) who also did not find a correlation between hope and the working alliance. Therefore, it is most likely that the results indicate that hope and the alliance co-exist independently of one another and make separate contributions to the counselling process.

Self-Criticism

The finding that self-criticism was negatively related to hope is consistent with previous research that found hopelessness to be positively related to self-criticism (Riley & McCranie, 1990). The present study found that individuals with higher levels of self-criticism had lower levels of hope at session 1 and session 5. Upon termination, however, the relationship between hope and self-criticism was no longer significant. Because self-criticism was measured only at the beginning of counselling, it is unknown whether self-criticism improved during counselling. The reasons for the loss of a significant association between hope and self-criticism at termination are unclear, but several possibilities exist. For example, it may be due to hope improving while self-criticism remained stable after session 5. Or, the loss of significance may reflect fewer participants upon termination. Because the analysis indicated that those participants who completed the study did not differ significantly on self-criticism than those who did not, it is known that the loss of significance was not due to the remaining participants having different initial levels of self-criticism.

The strong negative relationship between hope and self-criticism is consequential since hope has been found to increase during counselling both here and in other studies (e.g. Irving et al., 2004; Kraatz, 2003), and self-criticism and the related concept of perfectionism have been observed to be a barrier to successful treatment (Blatt et al., 1995; Rector et al., 2000). Hope may be a key factor to helping self-critical individuals benefit from counselling, while the importance of reducing self-criticism is also implied. Self-criticism as a moderater to other counselling process variables should be further explored.

The finding that the working alliance was not correlated with self-criticism contradicts the study of Zuroff et al. (2000). Because self-criticism has been found to be an impediment to counselling success, the relationship between self-criticism and the alliance is an important one to explore. It is possible that the relationship between perfectionism and the working alliance reported by Zuroff et al. is true only for depressed clients, or specific to perfectionism and not self-criticism. The present study did not screen participants; therefore, a wide range of presenting issues is represented, which may have reduced the significance of a relationship between self-criticism and the alliance. It remains to be determined whether the results of Zuroff et al. apply only to a depressed population, only to perfectionism and not the related concept of self-criticism, or whether the results of the present study are truly anomalous.

Reducing self-criticism has been found to improve treatment outcome (Rector et al., 2000), which may explain the significant correlation between self-criticism and psychological health in session 1, and the non-significant correlation between self-criticism and the GHQ by termination. Because self-criticism was only measured once in the present study, a reduction in self-criticism cannot be assessed. However, because the initial measure of self-criticism was not related to later measures of psychological health it does appear that lessening the influence of self-criticism is important to psychological health and the process of counselling.

Implications for Counselling Practice

As pointed out by Herth (2005), the way in which hope is conceptualized affects clinical practice. The same is likely true of counselling practice. Because this study has shown that hope continually increases throughout counselling, even when the measure

used included items of both specific and general aspects of hope, the findings imply that hope increases over and above that related to specific life and counselling goals. Thus, hope increases in terms of relationships, seeing one's personal patterns of hope across time, and other aspects that may not be related to the issues for which the client originally sought counselling. This supports the notion of addressing a client's hope during counselling and regarding an increase in hope as a sign that counselling is progressing.

That hope and the alliance were not found to be correlated in counselling has important implications for practitioners. Both were found to be important yet distinct elements of counselling, which suggests that while they may both be imperative to successful progression of treatment, an increase in one does not indicate a change in the other. For example, although a client's hope may be high, this does not mean the alliance is adequately strong enough to produce a positive therapeutic outcome; therefore, the therapist would still need to monitor and work on developing a strong alliance to increase the likelihood of successful treatment. Conversely, with another client, although the therapeutic alliance may be strong, the client's hope would not be reflected by their reports of the alliance and their hope may still be low, which could affect the counselling process or treatment outcome. The present study found that the client's reported hope was related to psychological health, which suggests that the alliance alone does not ensure a positive therapeutic outcome or symptom reduction. Ultimately, counsellors and psychotherapists should consider hope and the alliance to be two important but separate elements of counselling that each need to be monitored and addressed, with the goal of each increasing during the course of therapy, and with the understanding that a change in both of these elements may be necessary for positive change to occur.

The strong relationship between hope and self-criticism also has important implications for counselling practitioners. Initial self-criticism correlated strongly with session 1 and session 5 measures of hope. At termination, the clients' self-criticism was no longer associated with their hope. Although, self-criticism was not measured at termination and it cannot be determined whether it improved during counselling, it can be understood that by counselling termination the initial level of self-criticism lost its potency in relation to hope. Because of the negative relationship between self-criticism and hope, it is hypothesised that self-criticism may need to improve in order that hope may improve and to maximize the benefits of hope. While past research has found the effect of the alliance to be important enough to monitor and target the alliance during counselling, the present research indicates the same is true of hope and self-criticism.

Implications for Future Research and Study Limitations

Several elements of the study led to limitations in the results of the study due to the consequential lack of information. While the main limitation was the study dropout rate, other elements, such as the small number of measurement times for the alliance, have simply resulted in certain lines of query being unanswered. Suggestions will be made for future research to address the study limitations and questions left unanswered by the present study, in order that a greater understanding of hope in counselling can be achieved.

While the dropout rate of the study did not appear to compromise the internal validity of the study, as the study completers did not differ on the measured variables from those participants who did not complete study, the dropout rate did affect the choice of statistical analyses. In effect, the contribution of hope and the alliance to therapeutic

outcome could not be analysed through regression analysis because the final number of participants who completed all three phases of the study was too small. Future research might address this issue, by studying the effect of hope to counselling outcome with a larger number of participants. Also, not collecting information on the reason for treatment termination led to difficulty in integrating some research results with past findings, particularly those related to the working alliance. Other researchers are encouraged to collect information on termination to gain a greater understanding of counselling variables.

While hope and the alliance were not found to be related, an existing relationship could be confirmed or denied by conducting a study with more participants and measuring hope and the alliance several times throughout the study. An increase in the number of research participants would increase the power of the study and the ability of the analyses to detect a relationship, if one does exist. In contrast, if a relationship were still not detectable when more participants completed similar measures, this would support the present study in suggesting that a relationship between hope and the working alliance really does not exist. In this case, determining the contribution that each make to outcome would give further insight into the elements of a successful counselling experience.

Measuring both hope and the alliance several times during a study, rather than just three times as was done here, would shed light on the fluctuations of both during counselling, and a more detailed examination of hope and the alliance could be conducted. It is possible that a more thorough understanding of the relationship may be

attained if the changes in hope and the alliance during counselling are explored in greater detail.

Though hope was found to increase significantly throughout the study, the nature of the study, being non-experimental, does not allow for causal inferences. Thus, while it was found that hope increased among counselling clients, it cannot be determined whether this increase in hope was actually due to counselling. Thus, it is still unknown whether counselling leads to an increase over and above that which may occur with the passing of time. Future research could address this issue by comparing the hope of counselling clients to a wait-list control group or to individuals who are not planning on taking part in counselling.

While the study results indicate that hope increased significantly during counselling, hope-focussed counselling has also been proposed as a particularly effective form of counselling because of its explicit focus on hope (Jevne, 1993; Edey & Jevne, 2003). What remains to be studied is whether hope-focussed counselling produces increases in hope similar to or greater than the increases in hope seen in other types of counselling, such as in the present study. Although, the study results support the importance of hope in counselling, it is unknown whether the effect of hope would be improved if hope were explicitly discussed as part of counselling.

Future exploration of the relationship between hope and self-criticism is also warranted. While hope does not appear to have been studied in relation to self-criticism, the study results show a strong negative relationship between these two client variables. While self-criticism has been found to have a mediating effect on counselling outcome (Zuroff et al., 2000), it is possible that its relationship to outcome is based on its

relationship with client variables such as hope or the therapeutic alliance. Clarification of the impact of self-criticism on important counselling variables may help practitioners to increase treatment success for self-critical clients.

Self-criticism was not found to be significantly related to the working alliance, which is a surprise finding, given previous research (Zuroff et al., 2000). The relationship between self-criticism and the alliance should be further explored, in order that the present anomalous finding be understood. It is possible that there were not enough research participants in the present study to replicate the relationship, but it is also possible that the previous findings are not generalizable beyond seriously depressed individuals. Participants in this study were not chosen based on their presenting issues and participants presented for counselling for a wide variety of reasons; therefore, it is possible that the effect of self-criticism on the therapeutic alliance as reported by Zuroff et al. is closely related to client depression. Future research should address whether the relationship between the therapeutic alliance and self-criticism is present only when depressed clients are studied, or whether this relationship is present for clients with other problems, too.

Conclusion

In summary, the described research was an exploration of hope and its relationship to the therapeutic alliance and self-criticism, all of which are elements common to all types of therapy. Participants were 67 adult clients at a university clinic seeking individual counselling.

While previous research and theory indicated that a relationship between hope and the therapeutic alliance is likely, a correlational analysis did not support this notion.

Thus, it appears that while both the alliance and hope increase during counselling, they may function relatively independent of one another. Future research could address how much of the therapeutic outcome is explained by these variables.

Self-criticism was found to be negatively correlated with hope, which supports the proposition that it mediates counselling outcome (Zuroff et al., 2000). The present study found that while hope continually increased, it was negatively correlated with self-criticism. This suggests that self-criticism has a negative impact on hope and that therapeutic interventions that address self-criticism are important to achieve a positive therapeutic outcome. The working alliance, in contrast, was found to be unrelated to self-criticism, which was an unexpected finding that contradicted previous research.

Self-criticism and hope were related to client reports of psychological health, which again suggests the importance of reducing self-criticism and increasing hope during counselling. The study did not allow for an exploration of which elements of counselling could effectively reduce self-criticism and increase hope, but future research could address this issue.

The study has important implications for counselling practice and future research. One of the implications for counselling practice is that hope may be an important indicator of counselling progress. Furthermore, the presence of a strong alliance alone does not give all of the information on counselling progression. The present research has led to many suggestions for future research to continue the exploration of the importance of hope in counselling.

Overall, the findings of this research are significant, as they support the notion that hope is an important factor in the counselling process. The importance of hope is

separate from the importance of the alliance, and likely explains some of the variance in counselling outcome and process that is not explained by the alliance. The relationship of self-criticism to hope and to psychological symptoms also adds to the view that the reduction of self-criticism is important in order to increase the success of counselling.

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